Disponible en ligne sur www.sciencedirect.com
ScienceDirect
Neuropsychiatrie de l'enfance et de l'adolescence 56 (2008) 358–364
neuropsychiatrie de l'enfance et de l'adolescence
http://france.elsevier.com/direct/NEUADO/

Original article

Children with gender identity disorder: Is there a best practice?

Enfants avec troubles de l'identité sexuée : y-a-t-il une pratique la meilleure ?

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Abstract

Almost 50 years of clinical observation and research on children with gender identity disorder have provided useful information on phenomenology, diagnostic and assessment procedures, associated psychopathology, tests of etiological hypotheses, and natural history. In contrast, best practice guidelines and evidence-based therapeutics have lagged sorely behind these other domains. Accordingly, the therapist must rely on the "clinical wisdom" that has accumulated and to utilize largely untested case formulation conceptual models to inform treatment approaches and decisions. Because of this state of affairs, dogmatic assertions about best practice should be avoided.
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Keywords: Gender identity disorder; Children; Treatment; Best practice; Evidence-based therapeutics

For several reasons, I think that it is timely to focus on therapeutics. We are now approaching the 50th "anniversary" of Green and Money's [1] seminal paper on young children with gender identity problems. Since then, there have been considerable advances, on several fronts, in understanding these youngsters. During this time span, we have learned a great deal about phenomenology, assessment and diagnosis, identification of associated features (e.g., the most common comorbid behavioral problems), exploration of etiological hypotheses, and long-term follow-up [2–6]. Because there are not a lot of research clinicians working in this area, the advances have come slowly, from the persistent efforts of a few investigators.

Regarding therapeutics, a comparative developmental perspective on gender identity disorder (GID) is essential. In my view, the most general statement that can be made is this: the prospects for therapeutic change with regard to GID become considerably less malleable over the life course. If we start with adulthood, for example, the evidence is reasonably strong that psychotherapeutic interventions are not particularly successful. Although GID in adults may wax and wane [7], there is little direct evidence that this fluctuation results from specific psychotherapeutic techniques or interventions. Very few adults with GID, as Chiland [8] has noted, are particularly interested in psychotherapy. The empirical evidence from adulthood suggests that gender dysphoria is best treated through hormonal and surgical interventions, particularly in carefully evaluated patients. The picture from adolescence is not that different from that of adults. In my view, many adolescents with GID are not particularly good psychotherapy candidates and there is certainly little in the way of empirical evidence, or even clinical experience, that psychotherapeutic techniques or interventions are particularly effective [9] although, again, the gender dysphoria may wax and wane. Cohen-Kettenis and her colleagues, in the Netherlands, have certainly provided some very nice empirical evidence that hormonal and surgical interventions may be the most effective way to resolve gender dysphoria in carefully selected adolescent patients [10–12].

In my view, the picture changes radically when it comes to children with GID. That is to say, it is my clinical impression that many of these youngsters, and their families, respond quite effectively to psychotherapeutic interventions. Although I have no doubt that the changes that one can observe in these youngsters can, in part, be attributed to "spontaneous remission", if I dare use such a term, I believe that the situation is more complex than this. In other words, I think that therapeutics can work with young children with GID.

DOI of original article:10.1016/j.neurenf.2008.05.010.
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0222-9617/$ – see front matter © 2008 Published by Elsevier Masson SAS.
doi:10.1016/j.neurenf.2008.06.003

However, here we face a serious problem. Although there is a reasonably large literature on therapeutic approaches (behavior therapy, psychotherapy and psychoanalysis, parent counseling, group therapy, etc.), a perusal of the treatment literature yields the sobering fact that there is not even one randomized controlled treatment trial for children with GID [13]. In the era of best practice and evidence-based therapeutics, this means that the highest standard of evidence (Level I: "evidence obtained from at least one properly designed randomized controlled trial") has not been provided. Although there have been some treatment effectiveness studies, which might qualify as Level II standards (e.g., "evidence obtained from well-designed cohort or case-control analytic studies"), much is lacking in these investigations (for reviews, see [13–16]). To put it plainly: there is a large empirical black hole in the treatment literature for children with GID. As a result, the therapist must rely largely on the "clinical wisdom" that has accumulated in the case report literature and the conceptual underpinnings that inform the various approaches to intervention. This putative clinical wisdom is at Level III ("opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees"). Of course, here one person's wisdom may be deemed ignorance by another.

1. Case formulation

In the absence of best-practice therapeutic guidelines, the case formulation, i.e., the clinician's underlying conceptual model, is what will organize the approach to treatment. In generating a case formulation, there are several factors that might be considered.

1.1. Biological influences

Some parents of children with GID (and therapists) can be characterized as "biological essentialists". That is, these parents take the position that their child was "born that way". A few years ago, there was a very interesting case in the United States that was publicized in the mass media that is illustrative of this point [17]. The parents of a six-year-old boy with GID, living in the state of Ohio, attempted to register their son, whose birth name was Zachary, at school as a girl, with the given name of Aurora. Someone at the school apparently was concerned about this and notified the child welfare authorities, who then took the child into care. Media reports indicate that the parents have had various concerns about their son, not just in the domain of gender identity, the parents have had a number of psychiatric difficulties themselves, and the father revealed to a reporter that he wished to have a sex change operation himself, etc. From the media accounts, the parents appeared to be of the view that their child was born this way and that they were simply acting in the child's best interest by facilitating the transformation so as to reflect his true nature.

Since the story of Aurora was published in 2000, there have been a flurry of media articles and clinical essays about some parents and clinicians who have taken a very different stance from the more traditional approaches to therapeutics for GID in children [18–25]. This alternative approach is characterized as "gender-affirming": the diagnosis of GID is fiercely rejected and, in its place, terms such as "gender-variant" or "transgendered" have been used; the therapeutic approach has been to support the child in transitioning to living as the opposite sex. The novelty of this perspective is that some parents and therapists are adopting this approach with preschoolers and children just entering the school system, a developmental far cry from supporting transition among adolescents who appear to be locked into a cross-gender identity. Such children and their families have been highlighted on widely-watched television programs in the United States, including the Oprah Winfrey Show (May 12, 2004) and ABC's 20/20 (April 27, 2007). Additionally, a new parent-initiated website (TransKids Purple Rainbow Foundation; http://www.transkidspurplerainbow.org/) has been launched for families who opt for this therapeutic approach.

Several years ago, Langer and Martin [26] made an interesting argument consistent with the essentialist paradigm. They argued that "attempting to change children's gender identity [for the purpose of reducing social ostracism] seems as ethically repellant as bleaching black children's skin in order to improve their social life among white children" (p. 14). This is an interesting argument, but I believe that there are a number of problems with the analysis. I am not aware of any contemporary clinician who would advocate "bleaching" for a Black child (or adult) who requests it. Indeed, there is a clinical and sociological literature that considers the cultural context of the "bleaching syndrome" vis-à-vis racism and prejudice. Interestingly, there is an older clinical literature on young Black children who want to be White [27] – what might be termed "ethnic identity disorder" – and there are, in my view, clear parallels to GID. Brody's [27] analysis led him to conclude that the proximal etiology was in the mother's "deliberate but unwitting indoctrination" of racial identity conflict in her son because of her own negative experiences as a Black person. Presumably, the treatment goal would not be to endorse the Black child's wish to be White, but rather to treat the underlying factors that have led the child to believe that his life would be better as a White person.

The ethnic identity literature leads to a fundamental question about the psychosocial causes of GID. Just like Brody was interested in understanding the psychological, social and cultural factors that led his Black child patients to desire to be White, one can, along the same lines, seek to understand the psychological, social and cultural factors that lead boys to want to be girls and girls to want to be boys. Many contemporary clinicians have argued that GID in children is the result, at least in part, of psychodynamic and psychosocial mechanisms, which lead to an analogous fantasy solution: that becoming a member of the other sex would somehow resolve internalized distress [28–30]. I would argue, therefore, that it is as legitimate to want to make youngsters comfortable with their gender identity (to make it correspond to the physical reality of their biological sex) as it is to make youngsters comfortable with their ethnic identity (to make it correspond to the physical reality of the color of their skin) [31].

The biological essentialist perspective adopted by some parents, therefore, creates an interesting and challenging therapeutic

conundrum because, in a nutshell, it ties one's hands. Here is how I think about the issue. The model that I endorse is to view psychosexual differentiation and its disorders as multifactorial, which includes biological influences. Indeed, over the years, I have certainly tried to carry out some research that identifies what the specific biological mechanisms might be [32]. The clinical perspective that I adopt, however, is that biological factors function in a "predisposing" manner rather than as a "fixed" influence. In other words, for many youngsters, biological factors may well predispose the development of GID, but because many youngsters with GID can resolve their unhappiness, this implies a malleability for gender identity differentiation. It is this perspective that I try and share with parents. This approach, however, is at variance with the biological essentialist perspective, both philosophically and empirically.

1.2. Age at assessment

I believe that, holding everything else constant, age at which therapy begins is an important variable. Here, the idea is that there is greater plasticity and opportunity for change in younger children than in older children. We certainly see this narrowing of plasticity or malleability amongst adolescents who present with gender identity concerns, as I have previously remarked. We know that a great deal occurs with regard to gender development during the toddler and preschool years and some have gone so far as to suggest that this period in development is akin to a sensitive period for gender identity formation.

1.3. Psychopathology in the parents

As is true for many other psychopathologies of childhood, the severity of parental psychopathology or psychiatric impairment is a risk factor with regard to therapeutics. Thus, I have been particularly attentive, over the years, to assessing the functioning of the parents and have a great deal of empirical data in this regard. As one example, using the Diagnostic Interview Schedule (DIS), a highly structured method of assessing psychopathology in adults (originally invented for epidemiological purposes), I have found that about 50% of the mothers of GID boys had two or more DIS diagnoses and about 25% had three or more DIS diagnoses. A composite measure of maternal psychopathology was a very strong correlate of a general measure of the child's psychopathology [33].

1.4. Psychopathology in the child

I have also been attentive to the issue of comorbidity in the child, i.e., the presence of other behavioral problems or formal DSM diagnoses. As I have reported elsewhere, we have found that, on average, children with GID have as many general behavioral problems as do a demographically matched sample of clinical controls [6,34,35]. About 10% of the youngsters that we see in our clinic have general behavioral difficulties that are so severe that they require some type of day treatment setting or special behavior class at school. These other difficulties, when they are present, clearly must be considered in developing an overall treatment plan.

1.5. Attachment relations between the child and parents

Because the signs of GID appear so early in development, it has long struck me as important to think about their genesis within the context of early attachment relationships. Thus, one aspect of my clinical research over the past 15 years has been to try and look at the quality of the child's attachment relationships. One of my students, Birkenfeld-Adams [36], showed that about 75% of young boys with GID had an insecure attachment relationship to the mother. Unpublished data suggest that a similar percentage of girls with GID also have an insecure attachment relationship to the mother.

1.6. Parental reaction to early cross-gender behavior

Over 30 years ago, Green [37] wrote, with regard to boys with GID, that "what comes closest so far to being a necessary variable is that, as any feminine behavior begins to emerge, there is no discouragement of that behavior by the child's principal caretaker" (p. 238). Over the years, our own clinical observations, as well as others, certainly dovetail quite nicely with Green's observation [38]. In my view, early parental tolerance or reinforcement of cross-gender behavior has been the rule, not the exception. It is understanding the reasons that underlie this early parental reaction that requires detailed clinical exploration, for there appear to be very diverse motivations.

2. Facets of therapeutic intervention

There are three components to our therapeutic approach:

- treatment of GID in the "naturalistic environment";
- treatment of the parents;
- treatment of the child.

2.1. Treatment in the naturalistic environment

By treatment in the naturalistic environment, I am referring to the ways in which parents can facilitate therapeutic change in the child's day-to-day environment. If we break this down into some component parts, such interventions can include the following:

- promotion of same-sex peer relations;
- encouragement of gender-typical and "neutral" activities;
- limit-setting of cross-gender behaviors;
- dialogues on gender between parent and child.

My rationales for these interventions are as follows:

- most children with GID prefer to play with members of the opposite sex. They often have very poor relationships with same-sex peers. The reasons for this are, I believe, quite diverse and efforts to understand the contributing factors are

important. It is my clinical impression that improvement of same-sex peer relations, when it is successful, plays a very important catalyst in helping a young child with GID to feel more comfortable about being a boy or a girl [39]. Sometimes one will hear from parents the observation that when their child was quite young, for reasons of circumstance, they had social exposure primarily to children of the opposite sex (e.g., in home day care arrangements). This appeared to result in a greater comfort in affiliating with opposite sex peers and in the emulation of cross-gender stereotypical interests and activities. In other instances, one has the impression of greater temperamental compatibility. Many boys with GID, for example, are quite anxious about, and avoidant of, rough-and-tumble or boisterous play [30]. Many such boys will report, therefore, that they feel safer and less threatened in the company of girls who, on average, are less drawn to this behavioral style in play. One also notes, in some mothers, particularly those who have experienced negative life events involving men, such as sexual abuse or assault, there is a great deal of anxiety about encouraging such play in their sons, conflating fantasy aggression with real aggression. Thus, these mothers often discourage any signs of rough play in their sons. Then, there is the issue of early gender mislabeling in some young children with GID [40]; for example, if a young boy, in effect, is labeling himself as a girl, there is a matching of self to others and peer relations are organized around this parameter. By middle childhood, it is certainly the case that children with GID begin to be mistreated by other children, particularly same-sex peers, and they are often ostracized for their cross-gender behavior [34]. This peer group dynamic thus perpetuates cross-gender peer affiliation although sometimes even this becomes problematic, as girls will exclude the boy from their social world or boys will exclude the girl from their social world, as the case may be. When one works with older children with GID or adolescents, painful peer group relations are often discussed with great emotion and intensity. In aiming to improve a child's same-sex peer relations, it is my impression that this can do a lot in helping the child to realize that there are, in effect, many ways to be a boy or many ways to be a girl;

- when I work therapeutically with parents, I essentially take a two-pronged approach. One approach is to encourage certain behaviors or interactions, as described above with regard to peer group relations. The other approach involves limit-setting on cross-gender behaviors;

In my experience, there are some technical aspects of limit-setting that are often misunderstood. Thus, the role of limit-setting in treatment requires some consideration of conceptual and contextual issues. A common error committed by some clinicians is to simply recommend to parents that they impose limits on their child's cross-gender behavior without attention to context. This kind of authoritarian approach is likely to fail, just like it will with regard to any behavior, since it does not take into account systemic factors, both in the parents and in the child, that fuel the symptom. At the very least, a psychoeducational approach is required, but in many cases, limit-setting needs to occur within the context of a more global treatment plan. From a psychoeducational point of view, one rationale for limit-setting is that if parents allow their child to continue to engage in cross-gender behavior, the GID is, in effect, being tolerated, if not reinforced. Thus, such an approach would contribute to the perpetuation of the condition. Another rationale for limit-setting is that it is, in effect, an effort to alter the GID from the "outside in", while individual therapy for the child can explore the factors that have contributed to the GID from the "inside out". At the same time that one attempts to set limits, parents also need to help their child with alternative activities that might facilitate a more comfortable same-gender identification. As noted earlier, encouragement of same-sex peer group relations can be an important part of such alternatives.

Another important contextual aspect of limit-setting is to explore with parents their initial encouragement or tolerance of the cross-gender behavior. Some parents will tolerate the behavior initially because they have been told, or believe themselves, that the behavior is "only a phase" that their child will grow out of or that "all children" engage in such behavior. For such parents, they become concerned about their child once they begin to recognize that the behavior is not merely a phase. For other parents, the tolerance or encouragement of cross-gender behavior can be linked to systemic and dynamic factors. In these more complex clinical situations, one must attend to the underlying issues and work them through. Otherwise, it is quite likely that parents will not be comfortable in shifting their position.

Case example

> Shawn was a seven-year-old boy with an IQ of 115. He lived with his middle-class parents and an older sister. Since the age of three, Shawn had engaged in all of the behaviors that comprise the GID diagnosis. Shawn's mother spoke on a regular basis with her pediatrician, who reassured her that the behaviors were "normal" for a boy "until" the ages of six or seven. Prior to the referral, Shawn was cross-dressing; when his mother spoke to him about it, he became tearful and said: "Mom, I just can't let go of wanting to be a girl". Apart from the GID, Shawn was emotionally labile and prone to temper tantrums when he did not get his own way. Shawn's parents had a close marital relationship and generally functioned well. The one clear area of disagreement in their relationship concerned Shawn's cross-gender behavior. In general, father deferred to mother with regard to parenting issues. Shawn's mother did not know if limit-setting was an appropriate approach to take with her son and the advice of the pediatrician reassured her that his behavior was "only a phase". During the assessment, it became apparent that Shawn's father had been "boiling" for many years with regard to his wife's tolerance and encouragement of the cross-gender behavior. The parents were stalemated on this issue and the mother would covertly buy Shawn Barbie dolls. The increase in Shawn's felt distress about being a boy and the recent increase in social ostracism led the mother to rethink her position. Clinical observation indicated that Shawn was

very attuned to his mother's position on various matters. Once she began to verbalize to Shawn that she wanted him to feel happier about being a boy, he rather easily stopped cross-dressing in her clothes, stopped playing with Barbie dolls and, with parental support, began to develop close friendships with other boys. With the shift in the family system, Shawn and his father were able to develop mutual interests and began to spend much more shared time together, which they both immensely enjoyed.

- in my view, the broader context in which these interventions should take place might be described as "dialogues on gender" between the parents and child. Some parents are quite anxious in putting the issue on the table so to speak. One framework that I suggest is that it is important for the parents to be open with their child regarding the issues that they are working on. I will encourage parents to try and be candid in a manner that is sensitive to the child's developmental level, whether this is along the lines of framing the problem as the child being confused or mixed up about himself or herself as a boy or as a girl or that the child is feeling unhappy about their gender, etc. This framework allows the child to have some understanding of the shift in the parent's position and also to realize that the issue is one in which the parents are working on as well.

3. Treatment of the parents

In my therapeutic work with some parents, we spend a lot of time discussing the day-to-day interventions. As a general rule, we suggest that the frequency of sessions be weekly, particularly at the beginning of treatment. The focus of this work depends very much on the particulars that the parents bring to the sessions. For some parents, for whom instituting such changes is done without ambivalence or reservation, less attention is needed to the particulars of the interventions. For other parents, however, in which the child's gender identity difficulties are embedded in a great deal of ambivalence, the focus of the sessions can be to explore the underlying dynamics. Very often, what is weaved into this is the broader complexity of the family system, the parent's relationship, and the individual problems of each parent. In these cases, the therapeutic work is much more complex, challenging and long-term.

Case example

Harry was a four-year-old boy with an IQ of 121. He had an older brother and lived with his parents, who were of a lower middle-class background. At the time of assessment, his parents were about to separate. During Harry's life, his parent's relationship had deteriorated as a result of many issues, including an affair on the father's part, multiple disagreements about life-style and parenting issues, and mother's deteriorating psychiatric state, which had required inpatient treatment after a suicide attempt when Harry was around 18 months old. Harry had displayed signs of cross-gender behavior since the age of two, including compulsive and frantic cross-dressing and the verbalized desire to become a girl. His mother expressed marked ambivalence about treating Harry's GID: "This is who he is. . . if I tell him not to, I will destroy his basic essence". Exploration of the mother's life history revealed many reasons for her ambivalence about men and masculinity. She had grown up in a family in which her father was largely absent, she had been gang-raped at the age of 13 (following which she developed a severe eating disorder) and, in her relationship with her husband, had found sexual intimacy increasingly aversive. For Harry's mother, fantasy aggression (e.g., sword play, squirt gun play) was equated with real aggression and she worried that if such behavior was encouraged in Harry that he would develop into a rapist. Apart from the mother's ambivalence about masculinity, she also enjoyed Harry's "feminine side": he would often brush her hair and bring her tea when she was depressed and bedridden. Thus, there was suggestive evidence that Harry took care of his mother and that, in her mind, there was the risk of losing Harry if he became more autonomous from her, which was equated with him becoming more masculine.

Case example

Heidi was a five-year-old girl with an IQ of 100. She lived with her working class parents. Heidi's mother reported a complex history of intrafamilial sexual abuse. She believed that sexual abuse was extensive in her family of origin, involving many first- and second-degree relatives. In my view, some of the mother's account of sexual abuse appeared to be along the lines of recovered memories activated in the course of individual psychotherapy. Heidi's mother suffered from debilitating health problems, resulting in multiple surgeries (some of which were likely unnecessary) and subsequent bed rest and met criteria for multiple psychiatric diagnoses, including dysthymic disorder and borderline personality disorder. When Heidi was two, her mother developed the belief that Heidi had been molested by her maternal grandfather. There was no physical evidence of trauma to the genitals and Heidi denied that her grandfather had ever touched her: "My mom keeps telling me that he did something to me, but he didn't. I keep telling her this, but she doesn't believe me". Although the mother had consulted various professionals about the matter, there had been no substantiation of the abuse. As the mother talked to Heidi about how dangerous the situation was, her behavior gradually transformed: she rejected wearing feminine clothing, insisted that her hair be cut short to look like a boy's, began to call herself by a boy's name and expressed a wish to have a sex change. During the assessment, her mother commented: "I wonder if I have scared her about being a girl. Maybe she looks at me and thinks 'I don't want to be like her"'. Despite this insight, Heidi's mother found it exceedingly difficult to desist in talking about the alleged sexual abuse, despite the fact that the parents had kept her from the grandfather for several years.

3.1. Treatment of the child

In my clinic, we typically see children in therapy once or twice a week. The general therapeutic approach is that of open-ended psychotherapy, hopefully informed by the case formulation, in which one attempts to understand the child's experience of his

or gender identity, the whole process of "meaning making", and so on. Unlike in the naturalistic environment, in which we take a more structured approach vis-à-vis limit-setting, the therapeutic environment is more open, in which cross-gender behavior is often expressed. The key, however, is to gently explore with the child the meaning of his or her cross-gender behavior, which is often tied to the "fantasy solution" that becoming a member of the opposite sex will somehow lead the child to feel that he or she will be happier or more valued.

In individual therapy, one can address various issues: cognitive gender confusion, rigid gender schemas, idealization of the opposite sex and devaluation of one's own sex, anxiety in relation to same-sex peers, the connections between separation anxiety and gender, representations of the parents, and triggers that fuel the cross-gender behavior.

Case example

Ben was a three and a half-year-old boy with an IQ of 110. He lived with his upper-middle class parents and a younger sister. His father worked long hours and had little involvement in his life. Ben's relationship with his mother was enmeshed and her parenting style was to give him anything that he wanted. Ben's mother was an extremely anxious woman, who could not tolerate separations from him. She often ruminated about catastrophic events, commenting that: "if something ever happened to Ben I would kill myself. I could not live without him. He is part of me and I am part of him". When Ben's sister was born, he experienced her birth as a major displacement. Mother and relatives lavished great attention on his sister and his response was one of extreme jealousy. He became preoccupied with the color pink, the color of many of his sister's clothing. In the first months of therapy, all of Ben's drawings were made only with the colors pink and purple. In the therapy, I commented to Ben that he was very "jealous" of his sister, that he wanted to be like her because then he would have his mother back all to himself. He readily agreed. One key moment in the therapy occurred when his sister joined us in a session, when Ben was five and his sister was two. She was playing with a Barbie doll and Ben tried to take it from her. She resisted and Ben bit her forcefully on the arm. This afforded yet another opportunity to help Ben understand his underlying feelings of jealousy and towards his sister and his rage at his mother for "abandoning" him.

4. Conclusion

In summary, I conceptualize GID as multifactorial in its origin, as do others [30], which necessitates that one must go beyond biology in identifying additional factors that are part of the causal pathway. Accordingly, it is important to consider both predisposing and perpetuating factors that might inform a clinical formulation and the development of a therapeutic plan: the role of temperament, parental reinforcement of cross-gender behavior during the sensitive period of gender identity formation, family dynamics, parental psychopathology, peer relationships and the multiple meanings that might underlie the child's fantasy of becoming a member of the opposite sex. All of this requires an appreciation of the complexity of development.

References

[1] Green R, Money J. Incongruous gender role: Nongenital manifestations in prepubertal boys. Journal Nerv Ment Dis 1960;131:160–8.

[2] Cohen-Kettenis PT, Pfäfflin F. Transgenderism and intersexuality in childhood and adolescence: Making choices. Thousand Oaks, CA: Sage Publications; 2003.

[3] Drummond KD, Bradley SJ, Badali-Peterson M, Zucker KJ. A follow-up study of girls with gender identity disorder. Developmental Psychology 2008;44:34–45.

[4] Green R. The "sissy boy syndrome" and the development of homosexuality. New Haven, CT: Yale University Press; 1987.

[5] Zucker KJ. Gender identity disorder in children and adolescents. Annual Review Clin Psychol 2005;1:467–92.

[6] Zucker KJ, Bradley SJ. Gender identity disorder and psychosexual problems in children and adolescents. New York: Guilford Press; 1995.

[7] Marks I, Green R, Mataix-Cols D. Adult gender identity disorder can remit. Compr Psychiatry 2000;41:273–5.

[8] Chiland C. The psychoanalyst and the transsexual patient. International Journal Psychoanalysis 2000;81:21–35.

[9] Zucker KJ. Gender identity disorder. In: Wolfe DA, Mash EJ, editors. Behavioral and emotional disorders in adolescents: Nature, assessment, and treatment. New York: Guilford Press; 2006. p. 535–62.

[10] Cohen-Kettenis PT, van Goozen SHM. Sex reassignment of adolescent transsexuals: A follow-up study. J American Academy Child Adolescent Psychiatry 1997;36:263–71.

[11] Smith YLS, van Goozen SHM, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: A prospective follow-up study. J Am Academy Child Adolesc Psychiatry 2001;40:472–81.

[12] Smith YLS, van Goozen SHM, Kuiper AJ, Cohen-Kettenis PT. Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. Psychological Medicine 2005;35:89–99.

[13] Zucker KJ. Gender identity disorder in children, adolescents, and adults. In: Gabbard GO, editor. Gabbard's treatments of psychiatric disorders. 4th ed. Washington, DC: American Psychiatric Press; 2007. p. 683–701.

[14] Zucker KJ. Cross-gender-identified children. In: Steiner BW, editor. Gender dysphoria: Development, research, management. New York: Plenum Press; 1985. p. 75–174.

[15] Zucker KJ. Treatment of gender identity disorders in children. In: Blanchard R, Steiner BW, editors. Clinical management of gender identity disorders in children and adults. Washington, DC: American Psychiatric Press; 1990. p. 25–47.

[16] Zucker KJ. Gender identity disorder in children and adolescents. In: Gabbard GO, editor. Treatments of psychiatric disorders, Vol. 2, 3rd ed. Washington, DC: American Psychiatric Press; 2001. p. 2069–94.

[17] Cloud J. His name is Aurora. Time 2000 [September 25, p. 90–1].

[18] Adams C. Born in a bind: Treating transgender children. Gay & Lesbian Times 2007;1035.

[19] Brown, PL. Supporting boys or girls when the line isn't clear. New York Times; 2006 p. A1, A11.

[20] Ehrensaft D. Raising girlyboys: A parent's perspective. Studies in Gender and Sexuality 2007;8:269–302.

[21] Menvielle EJ, Tuerk C, Perrin EC. To the beat of a different drummer: The gender-variant child. Contemporary Pediatrics 2005;22(2):38–9 [41, 43, 45–46].

[22] Reischel J. See Dick be Jane. Broward-Palm Beach New Times 2006. Retrieved from http://www.newtimesbpb.com/2006-05-18/news/see-dick-be-jane/print (Retrieved on March 24, 2007).

[23] Saeger K. Finding our way: Guiding a young transgender child. Journal of GLBT Family Studies 2006;2(3/4):207–45.

[24] Santiago R. (2006). 5-year-old 'girl' starting school is really a boy. The Miami Herald. Retrieved on July 11, 2006 at http://www.miami.com/mld/miamiherald/living/education/15003026.htm.

[25] Smiley, L. (2007, July 11). Girl/boy interrupted. sfweekly.com. Retrieved from http://www.sfweekly.com/2007-07-11/news/girl-boy-interrupted/print.
[26] Langer SJ, Martin JI. How dresses can make you mentally ill: Examining gender identity disorder in children. Child Adolesc Social Work J 2004;21:5–23.
[27] Brody EB. Color and identity conflict in young boys: Observations of Negro mothers and sons in urban Baltimore. Psychiatry 1963;26:188–201.
[28] Coates S, Friedman RC, Wolfe S. The etiology of boyhood gender identity disorder: A model for integrating temperament, development, and psychodynamics. Psychoanalytic Dialogues 1991;1:481–523.
[29] Coates S, Person ES. Extreme boyhood femininity: Isolated behavior or pervasive disorder? J Am Academy Child Psychiatry 1985;24:702–9.
[30] Coates S, Wolfe S. Gender identity disorder in boys: The interface of constitution and early experience. Psychoanal Inquiry 1995;15:6–38.
[31] Zucker KJ. Commentary on Langer and Martin's (2004) "How Dresses Can Make You Mentally Ill: Examining Gender Identity Disorder in Children". Child Adolesc Social Work J 2006;23:533–55.
[32] Zucker KJ. Gender identity development and issues. Child Adolesc Psychiatr Clin N Am 2004;13:551–68.
[33] Zucker KJ, Lambert S, Bradley SJ, Owen-Anderson, A. Risk factors for general behavior problems in boys with gender identity disorder. Paper presented at the XIX Symposium of the Harry Benjamin International Gender Dysphoria Association 2005 Bologna, Italy.
[34] Cohen-Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ. Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. J Abnorm Child Psychol 2003;31:41–53.
[35] Wallien M, Swaab H, Cohen-Kettenis PT. Psychiatric comorbidity among children with gender identity disorder. J Am Acad Child Adolesc Psychiatry 2007;46:1307–14.
[36] Birkenfeld-Adams, A.S. (1999). Quality of attachment in young boys with gender identity disorder: A comparison to clinic and nonreferred control boys. Unpublished doctoral dissertation, York University, Downsview, Ontario.
[37] Green R. Sexual identity conflict in children and adults. New York: Penguin Books; 1974.
[38] Mitchell JN. Maternal influences on gender identity disorder in boys: Searching for specificity. Unpublished doctoral dissertation 1991, York University, Downsview, Ontario.
[39] Meyer-Bahlburg HFL. Gender identity disorder in young boys: A parent- and peer-based treatment protocol. Clin Child Psychol Psychiatry 2002;7:360–77.
[40] Zucker KJ, Bradley SJ, Kuksis M, Pecore K, Birkenfeld-Adams A, Doering RW, et al. Gender constancy judgments in children with gender identity disorder: Evidence for a developmental lag. Arch Sex Behav 1999;28:475–502.